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DR. SHAH: Good afternoon, everyone. On behalf of the Inclusion, Diversity, and Equity Advocates in Radiology, we call ourselves IDEA-RAD,

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I would like to welcome you all to this session titled, Care of the Transgender Patient, and before we move into the actual session, just a quick, few housekeeping tips for Zoom.

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Attendees will be able to post questions in the Q and A portion of the meeting, and you will see those in your Zoom navigation bar. The chat feature is not activated for the attendees for this meeting.

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We will try our best to bring, to discuss all of the questions that you posted in the chat and the Q and A portion will be at the end of the entire presentation by both our panelists.

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Panelists, please unmute yourselves as you speak and now, without further ado, we are going to go ahead with the actual session.

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My name is Zarine Shah, I am the Associate Professor in Radiology and I also serve as the Vice Chair for Diversity, Equity, and Inclusion for the Department of Radiology,

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and this particular event is put up by our event's subcommittee and I have Dr. Cubbison and Dr. Ismail on the call with us. Thank you both and for your team for all the work you put in for this event.

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IDEA-RAD is a group of 30 members, staff, trainees, and faculty working on several diversity initiatives.

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And this particular topic came up as one of interest to many in the department, so we decided to provide a session as an educational opportunity for all of us to learn more about it.

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And then, also as a first step to continue this conversation and make sure that we are able to provide high quality, equitable, and inclusive care to all the patients that we serve.

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Without further ado, I would like to introduce our first panelist, Dr. Andrew Keaster, who will start with the session on the educational component of this talk.

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Dr. Keaster attended medical school at OSU College of Medicine and continued here for his internal medicine residency.

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During this time, he helped create the OSUMC Gender Affirming Primary Care Clinic and he now works throughout the health system and regionally to educate about and care delivery for our gender diverse patients. Dr. Keaster, I will turn it over to you.

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And you can go ahead and share your screen.

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DR. KEASTER: Alright. Well, hi everyone. Thank you for having me today and I'm happy to be here to talk to you about a topic that's near and dear to my heart. Can everyone see my screen right now? - DR. CUBBISON: Yes. -

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Alright, so let's talk about caring for transgender patients. So, you know, I will say we're not going to get into a lot of

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you know, fine detail on the medical care and provision of say, hormone therapy, or, or surgeries

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for our trans patients. But, we, what we are going to do today is start with

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kind of a topical overview of, what does the word transgender mean? What are some terms that maybe we've heard before, or others that we haven't heard before, that are relevant to our discussion.

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And then we'll talk about epidemiology. What are some of the numbers, why it's important that we're even having this conversation today?

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We will look briefly at what it means for a patient to undergo a transition and some of the points of that transition where it may intersect with the

healthcare field. And then we'll talk about some basic communication techniques for working with trans, and gender-non...

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and gender diverse patients, and then we'll talk about also, briefly, some of the tools in IHIS that make it easier for us to see and navigate our gender diverse patients' charts.

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So, we're going to start with a cartoon. This is 'The Gender Unicorn'

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and I think it very simply pictorializes a few different concepts that are important to our discussion today. And so, we'll start with 'The Gender Unicorn', and what's between its legs, and that is the sex assigned at birth.

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Okay, so at birth, you know, a baby's born and the doctor says, "Oh, congratulations! It's a boy", or "It's a girl", or perhaps you have someone with an intersex condition. And so, typical terms for sex assigned at birth would be male, female, or intersex.

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Now, what we're not talking about today is going to be represented by who you give your heart to.

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And so, who you're physically attracted to, or emotionally attracted to. Again, there are several axes here where someone may be attracted to women, or attracted to men, whether physically, or emotionally, or perhaps both.

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And that's, would ultimately when related to your sex assigned at birth confer, you know, one sexual orientation, whether you're straight, or gay,

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etc. And again that's not what we're talking about today. We're talking about gender, and gender diversity, and so we'll look

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on our cartoon at the unicorn's brain. And so who you are in your headspace, how you feel about yourself, your hormone levels, and how that relates to

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how you think, and feel, and interpret the world around you as related to gender is going to be your gender identity. And so on the axes here, perhaps

a person is very much female-identified and very little male-identified, and so they would have a female gender identity.

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Some people, you know, maybe, are all male-identified and have very little or no female identity, and some people may have a little bit of both, or perhaps other genders, as well. And so I, sort of a 'typical

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person', right, and I use that in quotations, perhaps a person who's assigned female at birth, who has a female gender identity

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is what the term we'll use, cisgender. And then perhaps someone is assigned female at birth, but their gender identity is male, right. So, a difference, there's a difference there, there's an incongruence. And we use the umbrella term 'transgender' to apply to that individual. So...

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it does not have to be all or nothing. Again, 'transgender' is an umbrella term that, you know, perhaps someone has a little bit of both gender identities or multiple...

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sort of...

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feminine and masculine identities, or components of both. And again 'transgender' applies to all of these patients, and we'll see a few other terms that also help to sort of encompass

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this community, as well. Now that's gender identity, how you think and feel in your head, and gender expression is going to be your actions, and mannerisms, your physical presentation to the world

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as part of your gender.

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So, we will move on, and now I included on the next few slides just a lot of terms and we don't necessarily have to go through them in interest of time, but they're here for your reference, again.

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The acronym 'LGBT': Lesbian, Gay, Bisexual, Transgender. Oftentimes, there's a 'Q' at the end of that to include Queer.

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And 'LGB', those are sexual identities related to, again, who you give your heart to, physical or romantic attraction, and then the 'T' and 'Q': Transgender and Queer, refer to our discussion today with gender and gender identity.

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We mentioned sex assigned at birth is based on your assessment of external genitalia, as well as chromosomes.

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And then, your gender identity is your internal sense of self.

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So, words that we might hear related to this discussion. So, if we have a patient who is a transgender man, or trans man,

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or perhaps, a female to male individual. Again, there's various words in the community or colloquial that we may use or that we may use in the healthcare setting.

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But, a trans man is someone with a male gender identity, who was assigned female at birth and, conversely, a trans woman is someone who has a female gender identity currently and was assigned male at birth.

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The opposite of transgender is, as I said, cisgender, and that's when everything, you know, lines up.

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'Gender nonconforming'... other terms, 'genderqueer', and 'gender nonbinary' all refer to people who, you know, again, maybe there's a bit more complexity to the gender or maybe there's not an identity with male or female at all.

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So, transgender persons, you know, when we talk about a transition and when they meet us in the healthcare space,

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there's not a 'one size fits all' approach to what their needs might be. And so,

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some of our patients will request hormones to help sort of hormonally shift their bodies to more align them with their gender identity.

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Others will choose to surgically alter their body and pursue gender affirming surgery. Some will change hair and dress,

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Maybe add makeup,

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or wear certain prosthetics, or other things to shape their body differently to bring their physical appearance more in line with their gender identity.

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And just to repeat, sexual orientation and gender identity are separate contents and that's a common question we get and I just like to make that clear. Now, certainly

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the acronym LGBTQ is lumped together because your gender and sexual minorities have a shared history, oftentimes of discrimination. But when we break it down, they are different contents.

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This is a really busy slide. Okay, this is taken from the DSM-5, The Diagnostics and Statistics Manual, which is the psychiatry handbook for how we diagnose,

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well, mental illness. And so, I want to make it very clear that this is not

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for a discussion on mental illness. But, gender-

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'gender-identity disorder' is what it was previously known as, and then now on DSM-5 it's 'gender dysphoria'. And moving forward, I think we'll see it change even further, to be 'gender incongruence'. Okay, and so looking through here,

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basically, this incongruence, or difference, between your experienced or expressed gender. Okay, so saying your gender identity, on one hand.

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And then, a difference

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in the, between that and the assigned gender, so, what you were assigned at birth. Okay. Manifested for at least six months duration,

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and by any of these six characteristics.

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Now, in the clinical world, quite honestly, you know if someone calls in and schedules an appointment with me and says, "Hey, I want to see Dr. Keaster in the Transgender Clinic", and there's a waitlist of

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maybe three months or six months. By the time they get to me, they show up to the appointment while that time piece has already been established.

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Now, the last bullet here says, 'The condition is associated with clinically significant distress or impairment in social, occupational,

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or other areas of functioning.' And, you know, it's important to note, yes, some of our trans patients do experience distress or impairment, they have this dysphoria

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that impairs how they think and feel.

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But, that's not always true, okay, and, and you don't have to have a certain amount of distress, or dysphoria,

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or have experienced harassment, or, sort of, exogenously placed distress to be trans enough.

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And so, that's why this definition of 'gender dysphoria' isn't as inclusive as it could be, right? Because it applies only to people who experienced dysphoria, and why I think when we do move to 'gender incongruence' it will be a better umbrella term clinically to encompass all trans and

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non-binary identities, to allow access to the same range of hormones or surgeries.

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So, why is it important that we're here talking about this today?

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So, back in 2011, there was a large survey where trans people got to participate and answer questions about things that were important to them in various domains of

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their lives. So, we're going to look for the State of Ohio non-healthcare related, 80% of trans respondents in this survey said that they were harassed at work, 85% said harassed at school, 40% were physically assaulted at school,

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and 14% experienced sexual violence. Imagine trying to work, or learn, or grow in an environment where that, those were the statistics leveled against you. So, rather than thriving,

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the emphasis here is just on surviving, okay, and that's, that's not a good place to start.

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We have higher rates of unemployment, homelessness, and then... similar to other marginalized communities and minority communities, very high rates of discomfort seeking police assistance.

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Switching over to healthcare... So, 21% in this survey were refused medical care

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for their gender identity. That's not someone saying, "Hey, you know what, I don't know how to answer this question for you. Let me refer you over to the primary care,

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The Transgender Primary Care Clinic". That's someone saying, "Oh, wow. You know what, it burns when you pee? I don't understand what parts, you have, or you know,

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I'm just not going to treat you." Okay, and that's unethical, can't do that. Please don't do that, and at Ohio State we won't, and we are better than that.

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But, certainly, our patients come to us and many have had very disparaging, very damaging experiences when trying to seek health care, and that leads to oftentimes going without or postponing care when it's important.

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We see otherwise in this survey, higher rates of HIV infectivity and when you break that down to certain communities, particularly trans women of color,

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it's a significantly higher percentage of the population, almost 30%. We see lower rates of insurance and then highlighted here at the bottom, 44% in this survey reported attempting suicide at some point.

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Okay, that's not people who thought about attempting suicide and then didn't...

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or people who have really severe anxiety, or depression, or dysphoria. This is people who actually attempted suicide. It also does not include the people who completed

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suicide or died by suicide, I should say, and weren't able to take the survey. Okay, so significantly higher rates of suicide, attempted suicide, in our clinic when we ran the numbers for our first two years of patients. 45% of our patients here in Central Ohio have attempted suicide.

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And so, that drives a lot of the reason why we're here today. Okay, because we can do better, and we need to do better.

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A similar survey and overhaul of it, basically, in 2015 with many, many more participants basically gave us a lot of the same data. So, I won't go through it all, specifically in the interest of time, but again 40% in this survey also reported attempting suicide.

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How many patients...

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does that apply to? Or, I guess, how many gender diverse persons are there in Central Ohio and, you know, that we might expect to, to interact with?

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So, in 2011, based on census data we had

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estimated about 8 million LGB individuals, Lesbian, Gay and Bisexual, and the think tank that went through this found about 700,000 people that they could glean through some of the records,

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that were trans. And so, about a 10:1 ratio. So, some fuzzy math on some shady statistics because, again, we don't ask that question in the US Census.

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So, flipping to just Columbus' community, where we have about an estimated 70,000

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LGB individuals. If you take that same 10:1 ratio and apply it here in Columbus, it would be about 7000. So, logarithmically, between one and ten thousand trans

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individuals here in Central Ohio. Now, what I can tell you is that there's other data to show that we often dramatically underestimate the number of

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gender diverse patients in a community, because you can't effectively know who is gender diverse unless you ask a two-step question. So, "What is your

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sex assigned at birth?". Followed by, "What is your gender identity?". And when those are incongruent, then you would know, "Okay, we have a gender diverse patient."

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How many of you have ever taken a survey where you were asked both questions? And the answer is, infrequently.

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When we see patients in the primary care setting, there is a list of things that are going to be important that we talk about that are

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oftentimes areas that are sort of pushed to the side, or neglected by the patient, or providers that they'd seen in the past. Access to health care being very important, knowing what hormones that maybe they've taken, or are getting elsewhere

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when they come to you. Other things like cancer screening, which we'll look at here in a little bit, for several reasons. One, was higher rates of things like alcohol and tobacco use which lead to higher rates of cancer.

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But, then also specifically,

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you know, screening parts that patients have, or may have dysphoria around, and building trust to eventually get to a point where cancer screenings are apart of the discussion you can have. And in particular, the most

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relevant one would be cervical cancer screening in trans men.

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Similarly, breast cancer screening in trans men, as well. So, really high rates of missed pap smears and mammograms in trans men.

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And then, certainly, point #8: depression and anxiety. Every patient, every time, talking about mental health, to know, "Hey, how are we doing mental health-wise?". Because, as we saw in those statistics earlier, it's absolutely critical that we do.

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Cancer screening guidelines included here for anyone's reference. But, I won't go through them, specifically. What I will summarize with by saying is if someone has a part that should be screened, that does not mean the first time I meet a trans patient

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I say, "Okay, well, let's get ready for our pap smear." Right? Because that would be inappropriate, and uncomfortable,

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and potentially damaging, and hurtful to the patient, right? And so building a relationship with and getting to know the patient and then saying, "Hey, I care about you and my interest is keeping you healthy and safe. And at some point,

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on the list of topics that we're going to talk about is going to be this and so maybe not next visit or the visit after, but eventually, we'll have that conversation."

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And we'll talk about ways that might make it safer and more comfortable for the patient. Maybe they say it's not something they're interested in, or will be

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possible, and other times, you know, you can get to a point where they do consent because they realize it's important for their health, and you can make it a safe and comfortable experience for them, okay?

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So, again, included for reference and these slides will be available, I think, for everyone if there are questions about it.

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Fertility is another topic that I will mention. Trans people, just like all people, can and do have families, okay? And sometimes they'll adopt children,

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and...

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Sorry, I know that glare's coming right in on my face.

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But, sometimes they'll adopt children, sometimes they'll have children prior to transitioning, and sometimes you'll have patients who are in the middle of a transition and will choose to maybe stop hormones,

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and you know get pregnant or have a child. Okay, and all of these are possible and we've had certainly several patients over the years create and grow families in all different methods.

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It is important to know if a patient is on testosterone and they want to get pregnant. You do have to stop testosterone, it is teratogenic.

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Identity documents. So, this is another place where physicians do play a role in helping patients who are undergoing a transition. So, when we think about our driver's license, it has an 'M' or an 'F' on it.

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And to get that changed, you do have to have a physician sign a form stating that you have or are undergoing...

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that you have undergone or are undergoing gender transition. That does not mean someone has to have a whole range of surgeries and be on hormones for some certain amount of time.

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In fact, we sign these forms commonly for patients on a first visit who tell us, "Hey, I'm trans. Can I also get this..."

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Can I get my gender marker changed on my license?". And so, that's one thing. Now, to get legally, through the federal government, through social security, passport, etc., it does require physicians draft a letter that is included in the application that the patient submits for that.

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Other things. So, I mentioned earlier that patients will often alter their sort of phenotypic appearance to bring their body more in line with their gender identity.

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And so, tucking, binding, and packing are always to enhance or shape

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the groin or the chest to sort of realign their phenotype with their gender identity. And then, hair removal is going to be something important for

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trans women, typically to help feminize the body and certainly as a requisite for gender affirming surgery. And vocal changes. Now, a trans man on testosterone

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who goes from a female body to a male body, testosterone will lengthen the vocal cords and will cause the voice to crack and then get deeper, just like male puberty.

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But, a person who's been assigned male at birth who had maybe several years or decades, even, of testosterone who has a deep voice and then gets placed on estrogen as a part of the feminizing regimen.

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Those trans women, unfortunately, nothing is going to reshape the vocal cords. And so, vocal coaching and vocal training with a speech pathologist or a speech therapist is going to be really the only way to kind of change the quality of the voice to feminize it.

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Really, the only mention of hormones that I'll make today, other than I just told you testosterone is the main hormone that we'll use for trans men, and estrogen or estradiol is going to be the main feminizing hormone,

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is that, you know, we use what's called, 'an informed consent model'.

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Previously, in decades past, there was sort of this traditional "letter" model that said, "Okay, you have to find a counselor, or therapist, or psychiatrist

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and see that person for months, and possibly up to six months, and get a letter that says, 'Okay, you're trans enough'. Now, you take this and find a doctor who will then prescribe a very regimented set of hormones,

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that would then have to be for a certain amount of time, and then you would be able to access, you know, potentially a range of surgical procedures after that."

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And what we found is obviously, just like most things in medicine, a 'one size fits all' model does not make sense, and in fact, really serves to gate-keep and limit access to care. Perhaps, you have someone who their insurance doesn't allow for counseling or mental health access.

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Or then, maybe maybe there's not a mental health therapist who is specialized in that in your area, but maybe you can find a physician, and so...

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Again, doesn't necessarily make sense and oftentimes, you know, like I said, I have patients who are not,

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who don't have significant dysphoria, but are gender incongruent and would benefit from or have a desire to be on hormones, right? You have other patients who maybe they decided to transition

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in later years. We have several patients who are 50s, and 60s, and 70s even, and no amount of hormone therapy, however long or however high of doses, are going to change their body

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as significantly as if you were to expose an 18 year old body to hormones.

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And so, skipping right to potentially surgical alteration might make more sense for those patients to minimize side effects of higher doses of hormones.

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And so, an informed consent model that says, "Hey, as your physician, I'm providing this information. You, as the patient, have access to it, and, you know, you have your own needs and concerns. Let's address those and let's choose what works best for you."

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Now, on the topic of gender affirming surgeries, listed for your reference is sort of a range of procedures and I'm happy to say here at Ohio State over the last three to four years, we've been working closely with

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our gynecology, urology, and plastic surgery, and ENT departments. And all have surgeons who are now partnered with, and working with us, to perform

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all of these procedures, with the exception of, at the bottom right, a phalloplasty. Everything else, we now do have a functional team here at Ohio State that's able to provide comprehensive surgical services here, in addition to our primary care and mental health services.

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So, when we have

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trans patients, or LGB patients, in general. Okay, because this next two minutes is not specific to trans patients, but it's applicable to many patients. It is going to be

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asking open-ended questions, and not making assumptions. So, if you take away nothing else from this entire lecture,

00:28:20.900 --> 00:28:27.440

just know that the first bullet point here is the most important thing I'm going to tell you today. When you meet patients,

00:28:28.580 --> 00:28:39.890

ask them their name. Okay, and at first that sounds simple. But, think about when you see patients, how often we walk in the room and say, "Hey, I'm Dr. Keaster. Are you Mr. Smith, or are you,

00:28:40.640 --> 00:28:51.260

you know, Ms. Shah?", or, you know, we add a title to the name that's on the chart when we address the patient and we make that assumption that the person in front of us is,

00:28:51.950 --> 00:29:02.750

or isn't, the person we've named, right? Our patients may use a title that's gendered differently, they may not go by that name at all. And so, by simply asking,

00:29:03.920 --> 00:29:08.360

"What's your name?", and then following that with, "Okay, and what pronouns do you use?".

00:29:10.070 --> 00:29:21.470

I think it's going to be the easiest and best way to create a safe space for patients, right? And that can be for any number of patients, right? My name's Andrew, but I go by Drew.

00:29:22.520 --> 00:29:32.840

Certainly, our trans patients, you know, they may have a masculine name on their drivers license, or they go by something entirely different, or they have a more feminine sounding name.

00:29:33.950 --> 00:29:44.660

There's, again, a whole... Or, maybe someone goes by their middle name instead of their first name. Again, there's so many reasons why, when we meet people, just ask their name and give them that safe space to identify.

00:29:47.060 --> 00:29:55.220

And then, when patients name themselves, or use pronouns, or name or identify people in the room with them, obviously respect that and go with that.

00:29:57.380 --> 00:30:04.610

If you make a mistake, if a patient who, maybe they're assigned male at birth and they identify as a woman, and they tell you

00:30:05.660 --> 00:30:10.340

their name and that they use female pronouns... If you mess up and you recognize it,

00:30:11.450 --> 00:30:26.150

pause, look at them, and say, "Hey, you know what, I'm sorry. I just used the wrong pronoun. I'll do better next time.", and then go forward and do better next time, right? Misgendering patients is one of the worst things we can do.

00:30:27.320 --> 00:30:31.250

Even with the best intent, it shows...

00:30:32.420 --> 00:30:48.110

sort of, disrespect. And at worst, can be outright hostile to patients when we intentionally use the wrong gender, okay? And we can't do that at Ohio State, but when we mess up, even with the best intent, we do need to apologize.

00:30:50.330 --> 00:30:53.600

Alright. So, in the interest of time,

00:30:55.340 --> 00:31:11.090

I've got a couple different assumptions here that you can read through if you're interested. We make assumptions all the time. I mentioned, we make assumptions about names of patients, but then, we also make a lot of assumptions, I'll just read some through here.

00:31:13.130 --> 00:31:17.690

You know, assuming that trans or LGB patients don't have children or aren't in families.

00:31:18.710 --> 00:31:26.510

When it comes to sexual behavior, that gay men have never had sex with women, or vice versa, that lesbian women have never had sex with men.

00:31:28.280 --> 00:31:31.370

Or that straight people haven't had sex with people of the same gender.

00:31:32.960 --> 00:31:35.270

Assumptions that domestic violence doesn't occur...

00:31:36.320 --> 00:31:48.230

That, when it comes to trans patients, you know, that they want or need certain specific surgeries or hormones. When, in part, again, everyone's a little bit different with what they need for their transition.

00:31:49.520 --> 00:31:55.370

And then the last thing I'll say, in, in the exam room, it's important that not all patients have the same comfort

00:31:56.120 --> 00:32:13.460

with names for body parts. And so, before we launch into a discussion about screening for cervical health, or breast cancer, asking the patient, "Hey, we're going to talk about this region of the body. Are there terms that are off-limits to you, or terms that you use to describe your anatomy?".

00:32:18.800 --> 00:32:24.140

Think we covered a lot of that... Alright, so looking lastly at IHIS functionality.

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It appears my graphic is not loading, so I will just take a moment to say when you are looking at a chart in IHIS,

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if you hover over in the top left, the name of the patient, it will pop up a little submenu that shows you demographic information about the patient. And oftentimes, that will have

00:32:46.910 --> 00:33:01.340

the legal name, but it will also include a nickname, or a preferred name, if that's been added to the chart, which registration staff and physicians both have access to do under the 'Demographics' tab, which I would show you here, but I can't.

00:33:03.050 --> 00:33:11.750

But, you have the option to add a preferred name to a patient's chart and if the patient has a gender identity that is different from their legal sex,

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or from their sex assigned at birth. IHIS has the ability embedded in some smart forms

00:33:19.730 --> 00:33:27.140

in the 'Demographics' tab to specify, right? Someone might be male assigned at birth, have a female gender identity,

00:33:27.650 --> 00:33:38.150

and their legal sex may still be male, maybe they've updated it. But, knowing all three of those is important because those pull to different areas. Natal sex pulls to your health screening.

00:33:39.650 --> 00:33:44.960

Legal sex is going to be what is on the chart, that has to be reflected there. And then,

00:33:45.740 --> 00:33:56.480

their gender identity is going to be how we refer to the patient, and how we talk to them, and what pronouns we use. And so, knowing each is going to be important and that is present in IHIS.

00:33:57.050 --> 00:34:04.820

But, if there are questions about it, if you hover your mouse over the name in the top left corner, it will pop up a little list and give you more of that information.

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Alright, here's a flyer for us over in the primary care world. We've got five physicians here who all, one to two half days a week, see patients and then we have an endocrinologist,

00:34:18.110 --> 00:34:28.610

not pictured here, who also does. And then, of course, the teams I mentioned in our gynecology, ENT, urology, and plastics, who also see our patients.

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So, that's pretty much all I have. Just to quickly wrap up, please respect the self-identification of our transgender patients, right? Ask their name

00:34:39.650 --> 00:34:43.220

and respect that name and the pronouns that they use.

00:34:44.060 --> 00:34:53.720

Certainly, on the medical side of making sure we're looking for and treating concomitant mental health disorders, like depression, anxiety, because again, those statistics do happen to run quite high.

00:34:54.260 --> 00:35:01.550

And then, don't be afraid to ask questions, and, you know, if you certainly, if you make a mistake, please apologize and, and

00:35:02.450 --> 00:35:18.320

do better. Frequently assess your own level of comfort, and if you have questions, and want to learn and grow in this area as you see more of our patients as they come into the healthcare system, please reach out. I'm happy to chat about that. So, thank you very much for your time.

00:35:21.290 --> 00:35:34.550

DR. SHAH: Thank you, Dr. Keaster. That was, that was great, and like you said at the beginning, obviously, there is a lot more to learn, but I appreciate

the fact that you've at least given us an overview of what we can start ourselves, educating ourselves with.

00:35:35.060 --> 00:35:47.870

Again, just reminding the attendees, we will have a Q and A that will be after the second half of the session. So, please go ahead and submit your questions into the Q and A part of the Zoom meeting. I'm now going to share my screen again.

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And this is the second part of our session today. Are you able to see my screen?

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Yes? - Not yet. - Not yet. Okay, and I think you should be able to see it now. Yes? Awesome.

00:36:05.270 --> 00:36:14.780

So, for this second part of the session, I would like to thank Dr. Leah Braswell from Nationwide Children's Hospital for agreeing to be on this, on this session today.

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She is Associate Professor, Associate Chief of Interventional Radiology at Nationwide Children's Hospital. She trained at the University of Arkansas and Arkansas Children's Hospital, where she began her interventional radiology practice.

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Came to Nationwide Children's in 2016. Her clinical interests include all aspects of pediatric IR, including caring for patients with vascular anomalies and aneurysmal bone cysts.

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Dr. Braswell is an upcoming Pres-, upcoming President-Elect of the Society of Pediatric Interventional Radiology.

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Thank you, Dr. Braswell for reaching out to your patient and for taking the time to record this

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interview that we will be playing here shortly.

00:36:51.650 --> 00:37:02.330

And also, many thanks to the patient who agreed and, and the parents who agreed to share their experiences with us. So, from the entire Department of Radiology and all of us, please do convey our, our thanks to them, as well.

00:37:02.660 --> 00:37:17.780

DR. SHAH: I'm going to hand it over to you, Dr. Braswell...

DR. BRASWELL: Okay.

DR. SHAH: And I will share whenever you let me know.

DR. BRASWELL: Okay, perfect. No, similarly, I would really like to thank IDEA-RAD and the group for, for asking me to be involved today.

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My disclaimer is that I'm not an expert here, at all, and I don't have formal training. I've learned a lot from, from Dr. Keaster's presentation; that was excellent.

00:37:29.240 --> 00:37:45.770

But, you're going to hear from one of my patients. His name is, is Quinn and, and the story is that he's really the first patient that I knew well in a recurring format in, in IR who went through the, the transition process at Nationwide Children's.

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And so I,

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remember learning, just Googling, 'How do I act', 'What do I say', those types of things. So, I,

00:37:57.560 --> 00:38:04.700

I asked him on this interview that you're going to hear, some tips, you know, "What's it like when you come to the hospital or to a clinic?".

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And so, I hope you can see some of, some of those tips that I learned along the way. But, that's, that's my disclaimer is that I'm here to learn, as well, and

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hopefully becoming more inclusive, as we go.

00:38:19.910 --> 00:38:20.450

Go ahead. Yeah, thanks.

00:38:24.650 --> 00:38:36.260

DR. BRASWELL: So, I am Leah Braswell. I'm happy to be here today with one of my former patients. I'm a pediatric interventional radiologist at Children's and I'll let Quinn introduced himself.

00:38:37.610 --> 00:38:45.440

QUINN: I'm Quinn. I'm a senior in high school and I use 'he/him' pronouns.

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QUINN: I have spinal muscular atrophy.

00:38:50.390 --> 00:39:00.030

QUINN: Yeah, I don't, I don't know what else. [Laughter]

DR. BRASWELL: Perfect, I love it. Thanks for being here today and thanks for being willing to talk with us and share a little bit about your experience.

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DR. BRASWELL: I'm sure that we will all find that really helpful for the future care of a lot of patients, so that's an awesome thing that you're doing for us.

00:39:07.910 --> 00:39:14.780

DR. BRASWELL: Just a reminder that there are no wrong answers at all. You're in a totally safe space and everything you say is,

00:39:18.350 --> 00:39:20.780

DR. BRASWELL: is helpful for all of us. So, we really appreciate it.

00:39:22.610 --> 00:39:29.090

DR. BRASWELL: So, tell us a little bit about your experience and what it's like coming out and in, in high school.

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QUINN: So, I found that it's, it can be very freeing. But, it's also definitely a challenge, sometimes.

00:39:38.540 --> 00:39:48.260

QUINN: Specifically, in like the way, when you come out, you have to come out to so many people 'cause like, there's, you just know a lot more people than you think you know.

DR. BRASWELL: Right! [Laughter]

00:39:48.890 --> 00:40:01.790

QUINN: And I have found that it's very hard to keep track of who you've told, and who you haven't told, and so I find myself like asking people like, "Have I, have, I told you this?", and they're like, "Oh, yeah, yeah.", I'm like, "Okay, good."

00:40:03.860 --> 00:40:15.410

QUINN: But, like, once you figure that out, it's very nice to be able to like, just be yourself and not have to like, worry about what other people think or...

00:40:17.360 --> 00:40:17.660

QUINN: Yeah.

00:40:18.680 --> 00:40:34.130

DR. BRASWELL: Are there people that only know you as Quinn?

QUINN: Yeah.

DR. BRASWELL: That's kind of cool, too, I would assume.

QUINN: Yeah, it's really nice. There's always that little bit of fear, that's like, "Oh my God, they're going to like, discover all of my dark secrets.", but like...

DR. BRASWELL: Yeah.

00:40:35.150 --> 00:40:36.650

QUINN: It'd very difficult for them to.

00:40:37.730 --> 00:40:41.000

DR. BRASWELL: Yeah, yeah. That's cool, that's cool. So...

00:40:42.050 --> 00:40:50.240

DR. BRASWELL: As part of that, just being from the medical community, what's it like coming to the hospital or clinic and having to have a new identity at, at

00:40:51.380 --> 00:40:57.800

DR. BRASWELL: a hospital?

QUINN: It can definitely be kind of anxiety-inducing if it's like your first few times,

00:40:58.910 --> 00:41:05.390

QUINN: or your first time going to a new clinic, just because if you haven't legally transitioned yet, all of your like,

00:41:06.740 --> 00:41:23.930

QUINN: dead name, and your wrong pronouns are all in the system. And so, you're definitely like, there's a high chance that you're going to not experience like, great things. But, once you tell them... I've only experienced good things from all the clinics that I've been to...

00:41:25.130 --> 00:41:33.680

QUINN: after I came out. They've all been really accepting and like, done their best to put my preferred name and pronouns in the, in the system for me.

00:41:34.700 --> 00:41:46.820

DR. BRASWELL: That's cool. And so, do you think that that will, I mean, how does it work in a system? That, that means it's a permanent change and anybody who looks at your chart for the first time can see that, right?

QUINN: So, what I found with

00:41:47.930 --> 00:42:05.060

QUINN: most hospital systems is they can't change my legal name in there, like the name that shows up in like big, bold letters, is my legal name, which has not been changed, yet.

DR. BRASWELL: Okay.

QUINN: But, there's usually a name, place that's like, 'Preferred name', or, 'Nickname', and that's where they put it.

00:42:07.070 --> 00:42:08.780

QUINN: And usually, that can be...

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QUINN: extra, like... Put a little star next to it to be like, 'This is the name they want, like, this is not a nickname.'

DR. BRASWELL: Right.

00:42:20.630 --> 00:42:38.960

QUINN: But, some places still kind of disregard that because I think they think it's a nickname, which is kind of weird, a little bit, but.

DR. BRASWELL: Do you have to prompt people to use your preferred names in, in those kind of situations, like when you're checking in?

QUINN: Not usually, if they use my name

00:42:41.210 --> 00:42:51.980

QUINN: that I want them to be using, I don't have to. Like, if they just immediately, off-the-gate do it. But, if they say, like, my legal name, it's like, "Um... my- Do you have

00:42:52.850 --> 00:43:00.960

QUINN: Quinn in there? Because that that should be my name; that's what my name is." And then, they're like, "Oh, yeah. Sorry, I didn't, I didn't realize."

00:43:01.380 --> 00:43:09.320

DR. BRASWELL: Good, good, good. Well, I think that's, that's reassuring that you've had, for the most part, pretty, pretty comfortable experience. I mean, what are, what are some

00:43:09.680 --> 00:43:18.800

DR. BRASWELL: awkward situations, or a sticky thing, or what... Has anybody said anything that's, that's not so cool?

QUINN: The only thing that I'm thinking of is, like...

00:43:20.870 --> 00:43:34.400

QUINN: when they, when it is not in the system, and you have to kind of be like, "Can you please put it in there?". Like, especially with my local hospital, it's a lot more difficult because they're like a smaller...

00:43:36.920 --> 00:43:38.990

QUINN: [Inaudible remark] Children's is ginormous.

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DR. BRASWELL: Right.

QUINN: But...

00:43:42.680 --> 00:43:53.210

QUINN: I don't think, I think I have my, I think I have claimed in my, like, OhioHealth account or whatever...

DR. BRASWELL: Yeah.

QUINN: But...

00:43:54.800 --> 00:44:04.730

QUINN: For some reason, it's not used as often.

DR. BRASWELL: Right.

QUINN: For my prescriptions or checking in, which is confusing.

DR. BRASWELL: Right, right.

00:44:06.740 --> 00:44:15.290

DR. BRASWELL: What are some, what are some things that you know that we could do to make you more comfortable in the healthcare system.

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QUINN: So, a good, specific example that I have is that

00:44:25.580 --> 00:44:33.200

QUINN: in one of the other departments I've been in, you know how you get your name bracelet, or little sticker with your name and your ID number on it,

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QUINN: that has your legal name on it. If you know that you have a patient that's gender diverse, scribble their name out with a Sharpie and then write their name under it because that's what...

00:44:46.730 --> 00:44:53.480

QUINN: I go to the Thrive Clinic at Children's and that's what they do for me, and I was like, "Oh my God. Look these scribbled my name out." [Laughter and inaudible remark]

00:44:55.730 --> 00:45:01.580

DR. BRASWELL: Is that, how does that make you feel?

QUINN: I was like, "Oh my- This is weird, this is not right." [Laughter]

00:45:02.600 --> 00:45:14.030

DR. BRASWELL: Yeah, yeah. No, I mean, you must, you know, that, that shows that they see you, right? And that they're like, doing an active thing,

QUINN: Yeah.

DR. BRASWELL: like actually scribbling that sounds like,

00:45:14.930 --> 00:45:26.210

DR. BRASWELL: a huge step. I think that's really cool.

QUINN: Yeah, and then, I think also along those same lines, to like, be more like, to make gender diverse people feel more comfortable...

00:45:27.470 --> 00:45:35.960

QUINN: Pronouns-wise, you could wear pronouns pins or have your little pronouns like on your lanyard because that always was like, "Oh my God.

00:45:36.980 --> 00:45:45.080

QUINN: They have their pronouns, that means they're a cool person."

[Laughter]

DR. BRASWELL: Okay, cool.

QUINN: And then, you could always ask your patients what their pronouns are.

00:45:45.950 --> 00:46:01.670

QUINN: And, or put it in their file or something, like offer... So.

DR. BRASWELL: Yeah, so anytime we can start that conversation with either, with words or, or lanyards, or bag buddies, that's super helpful, huh?

QUINN: Mhm.

DR. BRASWELL: Cool, cool.

00:46:03.230 --> 00:46:08.900

DR. BRASWELL: What else do we need to know? Any other thoughts or tips? Those are awesome.

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QUINN: I think that, one extra thing. I never experienced this, but I know a few people who have. With, when you ask about their preferred name and pronouns,

00:46:22.070 --> 00:46:33.890

QUINN: try to do it in confidence, in case their family members are there that are homophobic or transphobic, because I have seen and heard stories where that has not gone down well.

00:46:34.820 --> 00:46:43.640

DR. BRASWELL: No, that's especially helpful for us at the Children's Hospital. I mean, I'm sure everywhere. But, because you don't know who somebody's coming to the hospital with and you don't know how,

00:46:45.020 --> 00:46:55.340

DR. BRASWELL: how 'out' people are in different settings within their lives, so I think that's super helpful, as well.

QUINN: Yeah, and I think it also makes the kid feel a lot more comfortable if they can get that off their chest

00:46:56.480 --> 00:47:00.080

QUINN: to the people who's taking, to the people who are taking care of them.

00:47:01.310 --> 00:47:13.670

QUINN: Especially, if they don't feel like they can be like that at home, you know?

DR. BRASWELL: Right. Yeah, that's super helpful I would think for, for pediatricians, as well. Just as part of adolescent health care, you know.

00:47:15.020 --> 00:47:23.150

DR. BRASWELL: There's always a time when the, when the kids have time with the pediatrician alone. I mean that could be added to the list of questions, so.

QUINN: Mhm.

00:47:25.550 --> 00:47:37.250

DR. BRASWELL: Awesome, alright. Well, we really, really appreciate you being willing to spend a few minutes with us. It's super helpful to see it from the patient's perspective, so that we know what we can do

00:47:38.000 --> 00:47:45.380

DR. BRASWELL: to make you comfortable when you come see us in any healthcare setting. So, that's great. We really appreciate that.

QUINN: Thanks.

DR. BRASWELL: Of course.

00:47:49.850 --> 00:48:01.070

DR. SHAH: Thank you, Dr. Braswell. That was really, as you said, you know, really something important for us to recognize and see from the patient's perspective, so that we can understand how we can help them better.

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We are now ready for the Q and A part of the talk and I'll turn it over to Dr. Alyssa Cubbison for the Q and A.

00:48:12.200 --> 00:48:27.470

DR. CUBBISON: Yeah. Thank you, again, Dr. Braswell and Dr. Keaster. That was really educational for us, yeah, and we just sort of want to open it up to the group to see is, is there anything that you want to reach out to either of them about, just regarding anything?

00:48:32.240 --> 00:48:36.950

I have a question to start. Probably more relevant for Dr. Keaster.

00:48:38.060 --> 00:48:49.160

I think, you know, in radiology sort of our, you know, our interactions with patients are often short. You know, we have this, you know, really precious amount of time to do a lot.

00:48:49.790 --> 00:48:58.010

You know, whether it's consenting, or delivering news, we have this really truncated amount of time to establish rapport and get patients to trust us.

00:48:58.310 --> 00:49:13.970

And then, all while accomplishing what we're trying to do, and so the idea of, you know, saying the wrong thing or, you know, potentially getting it wrong in the setting of maybe an already underserved patient population, you know, I would hate that to be the case.

00:49:14.990 --> 00:49:21.770

So, I know, sort of touching on what Dr. Braswell and Quinn had discussed, I know, because your clinic, you,

00:49:22.280 --> 00:49:36.620

you know, get to work with trans patients, every day. Is there a theme, or something that you'll you'll hear that maybe we just get wrong? Or maybe we, we sort of, something we need to be innocuous, but it's not. Is there, is there anything that comes to mind?

00:49:38.510 --> 00:49:51.650

DR. KEASTER: The, the most common thing is just the, the name assumption and using pronouns for a patient that are maybe based on an inaccurate chart and, and so,

00:49:52.670 --> 00:49:54.830

that kind of takes the...

00:49:56.690 --> 00:50:03.260

emphasis for making a mistake off of each individual provider and really puts it on the system that we use, right? We use a

00:50:03.650 --> 00:50:09.650

health information system, and it's supposed to help with care delivery. But, for our trans patients, oftentimes it

00:50:10.370 --> 00:50:18.950

does sort of, from the outside, get it wrong by misnaming, or dead-naming our patients, or using a gender that they don't identify with, and, and so...

00:50:19.370 --> 00:50:32.210

Really working to change the structure of the system to make, to where the the chart header, for people who don't need to know what the patient's natal sex is, just have it reflect their gender identity.

00:50:33.170 --> 00:50:55.040

For maybe, registration staff, or for lab staff, or blood bank, or radiology, the wristbands. Now, at least at Ohio State on the adult side, no longer have gender on there and they bold the preferred or chosen name and then have the legal name printed below that in smaller letters.

00:50:56.420 --> 00:51:14.240

And so, those have been some structural changes we've made in the last year or two to really help, again, us do better in sort of times, where there's sort of a quick interaction. Maybe transport is going to pick the patient up to take them through a radiology scan, or otherwise.

00:51:15.500 --> 00:51:25.670

You know, if their name band has the preferred name and doesn't include gender, it's less likely that we're going to get it wrong and misname or misgender our patients and, and so,

00:51:26.540 --> 00:51:34.760

really working in the system to change the structure, I think, is going to be better than any sort of individual action we can take.

00:51:35.150 --> 00:51:46.310

But, certainly being cognizant of, and each individual person here, absolutely introduce yourself to your patients and ask them what their name is and don't make those quick assumptions, that we so often do.

00:51:48.710 --> 00:51:57.950

DR. CUBBISON: Sure, and also to Quinn's point about maybe if they're with a, you know, a support person or, you know, family member that they've not come out to yet, that would sort of take that variable out of it.

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DR. SHAH: So, I, I had a question and I guess it's, it's one that, you know, both Dr. Keaster and Dr. Braswell, you could answer.

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And again, this is from a radiologist perspective and I'm one who doesn't see patients as often as Dr. Cubbison. I'm an abdominal radiologist and do diagnostics a lot, and so, for us, a challenge, sometimes is when we see patients who have undergone

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perhaps, a legal transition. So, their chart and their name reflects their gender that they've transitioned to, but anatomically they're still...

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So, there's a somewhat of a disconnect when we see their imaging and literally just, you know, their CDs or their MRI scans...

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that doesn't necessarily match up with what's, what we see their assignment on the, on, as a patient demographic. And I know that, you know, you talked about how we can change. Is there any other

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indication of this on the chart that we can easily look up? You know, as you said, you kind of hover over the patient's

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name in IHIS, and you can kind of see that transition. And then, I guess, a sort of second half of that question is for those who have undergone,

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I guess, gender reassignment procedures, perhaps. Is there something that we should be looking out for, specifically from the radiologist side of it?

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DR. KEASTER: Yeah, absolutely. So, hovering over the name if there's a discrepancy, or an incongruence, it will, it should highlight that in a little subbox that pops up. Two other places that you can see the 'Demographics' tab...

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If you go into the 'Demographics' tab, there's a subsection called, 'Clinical Information' that you can click on which will often

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be updated with sex assigned at birth, legal sex, and gender identity. Or, using the search feature, if you type, 'gender smart form',

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there is also, sort of in each patient's chart a gender smart form that defaults gender identity to what the legal sex is. But, it can be changed, and you can populate all of the additional information, and from that form actually you can even change

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the like health screening modifiers, right? So, if I have a trans man who's had a

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hysterectomy and mastectomy, I will, it will remove those...

00:54:29.360 --> 00:54:36.830

You know, you can remove those from the organ inventory on that gender smart form and then it will take the recommendations for pap smear and

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mammogram off of their health screening list. And so, within the last year or two, there have been a lot of structural additions to IHIS that allow it to be more

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functional for our gender diverse patients. But, it does require that someone in registration, or perhaps the primary care physician, has updated or changed those fields for the patient. If that has not been accomplished,

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then you, you wouldn't necessarily have access to that information.

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DR. SHAH: Thank you.

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DR. KEASTER: And was there a second half of that question? Oh, you said what

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sort of points, specifically for radiology, for imaging...

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That would be outside of my expertise, because I am not a radiologist.

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DR. CUBBISON: I sort of had a very brief kind of companion question to that. You know, in breast radiology, we will often get mammograms for patients that are potentially preoperative for bilateral mastectomy and I guess, just in terms of the phrasing,

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you know, oftentimes the way I'll phrase, that is, you know, patient is, you know, transitioning male to female or, you know, or whatever. Is there a, a preferred way that I think it's documented that, that you think of? Or is, you know, is that appropriate?

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There's a lot of variability in the names, and words, and vocabulary. Sort of early on, when I listed out a bunch of the different terms, you can use any number of them, and I think how we chart for ourselves, sometimes might be different than the vocabulary we use for patients. So,

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you know, using abbreviations like, 'M to F', or, 'F to M', or, 'Assigned male at birth', 'AFAB', or, 'AMAB', for assigned male or female at birth. Those are all quick designations that we might put in our documentation when we're charting.

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You know,

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I would never, when talking to a patient use, like, "Oh, hi. You're a male to female individual." That would be...

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clinical and probably offensive. And so, yeah, the way we document should be more in line with the way that we address patients, professionally and courteously. But, certainly, some abbreviations that are benign can be very helpful to help

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let us know, "Okay, this is a trans man." Maybe, 'Assigned female at birth' in parentheses after that. Just to let us know, "Okay.

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You know, naturally what might I expect to see on imaging, or what do I need to look for maybe if I do, or don't, see, you know, breast tissue. Okay, well, I can know that you had a mastectomy or maybe they never had breasts to begin with."

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So, yeah. There are ways that you can chart to clue your colleagues into if a patient has a trans identity, or was assigned male, or female at birth, or maybe has an identity as a trans man, or trans woman that's different from them.

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DR. CUBBISON: Okay, great. There's actually another question from the group.

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The question from, the question reads, 'In a world where patients can read all of their notes and results,

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are there any good ways that we can tailor our radiology reports to better serve and support our gender diverse patients, in addition to things like avoiding pronouns and gender terminology?'

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DR. KEASTER: So, that last part, right? So, just avoiding pronouns, and gender terminology, and describing anatomy, and scans, the way it is featured and not putting

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assumptions of gender in that.

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DR. CUBBISON: Good. So, it doesn't sound like we're missing the mark too much on using some type, you know, language we shouldn't be using in general, from, from what you've seen?

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DR. KEASTER: Now, I will say. There is one thing, and this is true across, even the primary care world, we still, even though we can add and edit

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names, and gender, and everything, the forms we use the smart phrases for our documentation,

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often pull from the sex assigned at birth. And we've tried to get it to where, you know, in your note template if it says like, 'Patient's name is a 40 year old', and then inserts a gender and sort of, those pre-populated

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fields, that often pulls from sex assigned at birth. And even if you update legal sex or others, that still populates with what is the patient's incorrect gender identity and, and so making sure, for our trans patient, when you look at a note,

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that it does update or if you're using templates that include that field, to delete it or edit it.

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DR. SHAH: Thank you, Dr. Keaster and Dr. Braswell. We are at time. Thank you all; have a great rest of your day!